KETAN D. VORA DO PC
NON-SURGICAL ORTHOPEDICS OF NEW JERSEY PC

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Date:_____ Patient's Name:_____

The purpose of this agreement is to prevent misunderstandings regarding pain medication. This is to allow for both you and your doctor to comply with the law regarding controlled pharmaceuticals.

1. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.
2. I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will reduce the medicine over a period of several days, as necessary to avoid withdrawal symptoms. Also, a drug-dependence program may be recommended.
3. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
4. I will not use any illegal controlled substances.
5. I will not share, sell or trade my medication with anyone.
6. I will not attempt to obtain any controlled medicine (including opioid pain medicine, controlled stimulants, or anti-anxiety medicine) from any other doctor.
7. I will safeguard my pain medicine from loss or theft. I understand that lost or stolen medicine will not be replaced.
8. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit. No refills will be available over telephone or without consulting in person with the doctor.
9. I understand I must allow up to 24 hours from an office visit to receive my medicine.
10. I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a

copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

11. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain management medicine.
12. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
13. I will bring all unused pain medicine to every office visit.
14. I agree that pain management appointments are my responsibility to keep and if they are missed without prior notice I will be scheduled into the next available appointment.
15. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient's Name: _____

Patient's Signature:_____

Provider: Ketan D. Vora, D.O / Bhupinderjit Singh, FNP-BC

Provider's Signature: _____

Witnessed by:_____